Electronically Delivered

May 20, 2024

Licensee
Healing Residences Inc
4800 5th Street Northeast
Columbia Heights, MN 55421

RE: Project Number(s) SL35538015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 25, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35538	A. BUILDING: _____ B. WING _____	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING RESIDENCES INC	4800 5TH STREET NE COLUMBIA HEIGHTS, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35538015 On April 22, 2024, through April 25, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 4 residents; 4 receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 22, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this	0 650		

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0 650	Continued From page 2 chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an employee record included documentation of training and competency for one of two unlicensed personnel (ULP)-C) providing direct care services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C was hired on June 1, 2023, to provide direct care services to residents of the assisted living facility.	0 650		

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0 650	Continued From page 3 On April 23, 2024, at 7:32 a.m., surveyor observed ULP-C administer R3's morning medications. ULP-C's employee record lacked documentation of registered nurse (RN) training and competency for oral medication administration. On April 23, 2024, at 11:45 a.m., ULP-C stated the nurse before the current clinical nurse supervisor (CNS)-B trained and worked the floor with her on medication administration and vitals. On April 24, 2024, at 10:35 a.m., licensed assisted living director (LALD)-A stated she could not find any competencies for medication routes or practical skills signed off by an RN for ULP-C. Additionally, she stated the nurse does competencies prior to the ULPs working alone with residents. On April 24, 2024, at 11:40 a.m., clinical nurse supervisor (CNS)-B stated new hires are expected to do online training, take a class with a registered nurse (RN), and the RN would sign off on a completion of competency. Additionally, CNS-B stated ULP-C was trained prior to her starting the CNS position. The licensee's Medication Administration policy dated August 1, 2021, indicated the RN may delegate medication administration to an unlicensed staff member (home health aide) according to the following protocol: all home health aides have passed a competency evaluation with respect to all medication routes to be administered; the RN has prepared written instructions for the home health aide in the proper methods to administer medications with respect	0 650		

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0 650	Continued From page 4 to each resident; and the RN has communicated with/provided orientation to the home health aide regarding the individual needs of the resident. [Facility] will maintain documentation of the competency evaluation for the home health aide in the personnel file and the orientation/instruction with respect to the Medication Management Plan for each individual resident in the clinical record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete a tuberculosis (TB) history and symptom screen on hire for one of	0 660		

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0 660	Continued From page 5 two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The facility's Tuberculosis (TB) risk assessment was completed January 30, 2024, and was determined to be a low risk level. ULP-D was hired March 3, 2022, to provide direct care services to the facility's residents. ULP-D's employee record included documentation of a negative QuantiFERON (TB blood test) on April 11, 2022, however, the employee record lacked a TB a history and symptom screen. On April 24, 2024, at 10:15 a.m., licensed assisted living director (LALD)-A stated she was unable to find ULP-D's TB history and symptoms screen and may have been missed on hire. The licensee's TB Screening and Prevention policy dated August 1, 2021, indicated baseline testing is completed on hire for all direct care providers. Baseline screening includes an assessment for TB history and current TB symptoms. No further information was provided. TIME PERIOD FOR CORRECTION:	0 660		

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0 660	Continued From page 6 Twenty-One (21) days	0 660		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide an interconnected smoke alarm that complied with fire protection requirements. This had the potential to directly affect all residents, staff, and visitors.	0 780		

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0 780	Continued From page 7 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 22, 2024, at 1:00 p.m., survey staff toured the home with licensed assisted living director (LALD)-A. During the tour, survey staff observed when smoke alarms were tested the smoke alarm in resident bedroom four was not activated. The smoke alarm installed in bedroom four was not interconnected with the other smoke alarms in the dwelling unit. During an interview on April 25, 2024, at 9:00 a.m., LALD-A verified the smoke alarm was not interconnected during the facility tour on April 22, 2024. LALD-A stated the resident living in bedroom four tampers with the smoke alarm. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	0 810		

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0 810	Continued From page 8 residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 810		

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0 810	Continued From page 9 or has potential to affect a large portion or all of the residents). The findings include: During the facility tour on April 22, 2024, at 1:00 p.m., the surveyor observed numbers were posted outside the bedrooms, but these numbers were not labeled on the facility floor plan identifying the resident bedrooms. Resident sleeping room numbers are required to be included on the fire safety and evacuation floor plan to provide efficient communication for exiting in the event of a fire or similar emergency. On April 23, 2024, the licensee provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP included a fire safety policy dated August 1, 2021. The FSEP fire safety policy included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. Employee actions for fire were limited to the RACE acronym (RESCUE, ALARM, CONFINE, EXTINGUISH). During an interview on April 25, 2024, at 9:00 a.m., licensed assisted living director (LALD)-A verified the FSEP required revision. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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01330	Continued From page 10	01330		
01330 SS=D	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff met all requirements for training and competency evaluations for one of two unlicensed personnel (ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	01330		

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01330	Continued From page 11 The findings include: ULP-C was hired on June 1, 2023, to provide direct care services to residents of the assisted living facility. On April 23, 2024, at 7:32 a.m., surveyor observed ULP-C administer R3's morning medications. On April 23, 2024, at 11:45 a.m., ULP-C stated the registered nurse (RN) (before the current clinical nurse supervisor (CNS)-B) trained and worked the floor with her on medication administration and vitals, does not remember being trained on the floor by the registered nurse (RN) for showering, safe transfer techniques, range of motion and positioning. Additionally, ULP-C stated all of the residents are independent on those tasks, some even work. ULP-C 's employee record included online training transcripts dated June 1, 2023, through June 5, 2023, indicating ULP-C completed the following trainings: -client mobility, to include exercise and ambulation, lifting and safe transfers, range of motion and positioning; -personal cares; -standby assistance techniques and how to perform them; -safe transfer techniques and ambulation; and -range of motion and positioning. ULP-C's employee record lacked demonstrated practical skills test listed in section 144G.61 subdivision 2, paragraphs (a) clauses (5) and (7) and (b) clauses, (5), and (6), and all the delegated tasks the ULP will perform: -appropriate and safe techniques in personal	01330		

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01330	Continued From page 12 hygiene and grooming, including, hair care and bathing, care of teeth, gums and oral prosthetic, use and care of hearing aids, dressing and assisting with toileting; -standby assistance techniques and how to perform them; -safe transfers techniques and ambulation; and -range of motion and positioning. On April 24, 2024, at 10:35 a.m., licensed assisted living director (LALD)-A stated she could not find any competencies for medication routes or practical skills signed off by an RN for ULP-C. Additionally, she stated the nurse does competencies prior to the ULPs working alone with residents. On April 24, 2024, at 11:40 a.m., clinical nurse supervisor (CNS)-B stated new hires are expected to do online training, take a class with an RN, and the RN would sign off on a completion of competencies. Additionally, CNS-B stated ULP-C was trained prior to her starting the CNS position. The Staff Competency policy dated August 1, 2021, indicated the director and CNS are responsible for assessing competency throughout the orientation. The following topics must be completed by a practical test: appropriate and safe techniques in personal hygiene and grooming, including bathing, hair care, oral hygiene (teeth, gums and oral prosthetics); care and use of hearing aids; dressing and toileting; safe transfer techniques and ambulation; and range of motion and positioning. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35538	A. BUILDING: _____ B. WING _____	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING RESIDENCES INC	4800 5TH STREET NE COLUMBIA HEIGHTS, MN 55421

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01330	Continued From page 13 (21) days	01330		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse documented resident-specific instructions for medications for one of one resident (R1) whose medication administration was delegated to unlicensed personnel (ULP). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	01750		

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01750	Continued From page 14 R1's diagnoses included schizoaffective disorder (mental health disorder), developmental delay and depression. R1's service plan dated April 9, 2024, indicated the resident received services to include medication administration, laundry, housekeeping, and bathing and grooming reminders. On April 23, 2024, at 7:33 a.m., surveyor observed ULP-C administer R1's scheduled morning medications. R1's electronic medication administration record (EMAR), dated April 1, 2024, through April 30, 2024, included the following: -bupropion 300 milligram (mg) tablet daily; -docusate 100 mg capsule daily; -propranolol 40 mg tablet twice daily; -sertraline 150 mg tablet daily; -divalproex 1000 mg tablet daily; -haloperidol 5 mg tablet daily; -melatonin 0.5 mg tablet daily; -quetiapine fumarate 50 mg tablet daily; -acetaminophen 500 mg, one to two tablets as needed for pain; -haloperidol 1 mg tab, one to two tablets as needed for agitation; -hydroxyzine 50 mg tablet as needed for moderate anxiety-may take twice daily; and -ibuprofen 600 mg tablet every six to eight hours for headaches. The licensee failed to provide resident-specific instructions pertaining to the following as needed pain and anxiety medications (parameters for dose needed, time frame between doses, and which medication to administer first): -acetaminophen 500 mg, one to two tablets as	01750		

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01750	Continued From page 15 needed for pain; -haloperidol 1 mg tab, one to two tablets as needed for agitation; -hydroxyzine 50 mg tablet as needed for moderate anxiety-may take twice daily; and -ibuprofen 600 mg tablet every six to eight hours for headaches. On April 24, 2024, at 11:13 a.m., clinical nurse supervisor (CNS-B) stated the staff would call her or the on-call nurse for direction on what medication to administer to the resident. CNS-B stated the EMAR was lacking specific instructions. The licensee's Medication Administration policy dated August 1, 2021, indicated all staff with responsibility for medication administration have access to information about the medication being administered, including but not limited to: purpose; dosage; route; frequency; instructions related to the medication and specific to the residents, as appropriate; side effects; and resident allergies to medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;	01790		

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01790	Continued From page 16 (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the	01790		

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	35538	A. BUILDING: _____ B. WING _____	04/25/2024

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01790	Continued From page 17 registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure two of two unlicensed personnel (ULP)-C, ULP-D) was trained and demonstrated competency to prepare and give medications for residents having unplanned time away when licensed nurse is not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 22, 2024, at 11:30 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility.	01790		

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01790	Continued From page 18 ULP-C ULP-C was hired on June 1, 2023, and provided services under the assisted living license. On April 23, 2024, at 7:23 a.m., surveyor observed ULP-C administer R3's morning medications. ULP-D ULP-D was hired on March 3, 2022, and provided services under the assisted living license. ULP-C and ULP-D's training record lacked evidence to indicate ULP-C and ULP-D was trained and had demonstrated competency to provide medications for residents for unplanned time away from home. On April 24, 2024, at 11:25 a.m., CNS-B stated the nurse would set medications up and fill out a form for medications being sent with resident for unplanned time away; if the nurse is not at the facility the staff would prepare the medications. Additionally, CNS-B stated the registered nurse (RN) prior must not have documented the training. The licensee's Medication Management Plan for Residents Away from Home policy dated August 1, 2021, indicated for unplanned time away from home, for temporary periods when an adequate medication supply cannot be obtained from the pharmacy or set up by the RN in a timely manner, the RN may delegate to ULP (home health aide) to provide the medications based on the following: -the RN has trained the home health aide and determined the home health aide competent to follow procedures for giving medications to resident;	01790		

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01790	Continued From page 19 -the RN has instructed the home health aide to ensure that all appropriate precautions are taken; -the registered nurse has developed written procedures/protocols for the home health aide, including special instructions regarding controlled substances (refer also to Protocol for Residents Away from Home), including, the type of container(s) to be used for the medications appropriate to the facilities medication system, how the container(s) should be labeled, and written information about the medications provided and documentation requirements; and -how the RN should be notified the medications were provided and whether the RN should be notified before the medications are given to the resident or designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01790		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *04/22/24*
Time: 14:46:32
Report: 7994241083

Food and Beverage Establishment Inspection Report

Location:

Healing Residences Inc
4800 5th Street Ne
Columbia Heights, MN55421
Anoka County, 02

Establishment Info:

ID #: 0038482
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6128063863
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW EGGS FOUND STORED ON THE TOP SHELF OF THE FRIDGE. STORE EGGS AND OTHER RAW FOODS ON THE LOWEST LEVEL POSSIBLE.

Comply By: 04/22/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

CFPM THAT WAS FOUND POSTED WAS A COPY. POST ORIGINAL COPY OF CFPM CERTIFICATE ON SITE.

Comply By: 04/26/24

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	0	1

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE

TEMPERATURES:

Food and Beverage Establishment Inspection Report

MILK 36
SLICED MEATS 38

DISHWASHER 180 F

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 7994241083 of 04/22/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____
Establishment Representative

Signed: Crystal Elva
Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us

Report #: 7994241083

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health

625 Robert Street North
St Paul

No. of RF/PHI Categories Out	2	**Date**	04/22/24
No. of Repeat RF/PHI Categories Out	0	**Time In**	14:46:32
Legal Authority MN Rules Chapter 4626		**Time Out**	

Healing Residences Inc	**Address** 4800 5th Street Ne	**City/State** Columbia Heights, MN	**Zip Code** 55421	**Telephone** 6128063863
License/Permit # 0038482	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight		
2	IN OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT	Proper use of reporting, restriction & exclusion		
5	IN OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed		
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN OUT	Food obtained from approved source		
12	IN OUT N/A N/O	Food received at proper temperature		
13	IN OUT	Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected		
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time & temperature		
19	IN OUT N/A N/O	Proper reheating procedures for hot holding		
20	IN OUT N/A N/O	Proper cooling time & temperature		
21	IN OUT N/A N/O	Proper hot holding temperatures		
22	IN OUT N/A	Proper cold holding temperatures		
23	IN OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used		
28	IN OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 04/22/24

Inspector (Signature) Crystal Elva